VALLEY PEDIATRIC ASSOCIATES, L.L.C.

9 Park Center Court • Suite 150 • Owings Mills, MD 21117
Phone: 410-902-7710 • Fax: 410-902-4410

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Request Release from:

Name or Physician or Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Information

Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize you to release a copy of my medical records to Valley Pediatric Associates, LLC, to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

Signature: _____ Date: _____

Relationship to Patient(s): _____

Please include the following items:

_____ Complete Medical Record

_____ Summary of Records

_____ All Visits

_____ Hospital Records

_____ Old records from previous physician

_____ Immunization Record

_____ Consultation Notes

_____ Laboratory Tests

I give special permission to release any information regarding treatment for:

_____ Alcohol / Drug Abuse
(Initial)

_____ Psychiatric treatment
(Initial)